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VENEREAL DISEASES IN ENGLAND AND WALES*

EXTRACT FROM THE ANNUAL REPORT

OF THE CHIEF MEDICAL OFFICER FOR THE YEAR 1960

VENEREAL DISEASES

The incidence of the main venereal diseases continued to rise during 1960 and gives cause for concern.

Syphilis.—In the Report for 1959 it was noted that the number of cases of early infectious syphilis treated at the clinics during that year had risen for the first time since 1946, apart from slight and transient increases in cases in males and females in 1955 and in females in 1956. The number of cases showed a rise during 1960 which relatively was considerable, although in absolute numbers still small (Appendix, Table B). It is still not certain that this rise indicates a trend which for the past few years has caused anxiety in other countries but has been slow to appear here. It is a development which will be closely watched. The increase has affected only males and is greater than can be accounted for by the minor fluctuations which occur from time to time. The fact that there is some reduction in cases in females is not reassuring because it suggests difficulty in tracing infectious contacts rather than diminished incidence of infection. In 1959 it was found that early syphilis occurred almost exclusively in large centres of population. Although this is still true in general, the returns for 1960 show sporadic cases of infectious syphilis occurring in rural areas, suggesting the possibility of wider spread which has already occurred with gonorrhoea. The following Table gives the number of early cases reported from ten urban areas in 1950 and 1960.

EARLY SYPHILITIC INFECTIONS DEALT WITH FOR THE FIRST TIME IN 1959 AND 1960 IN TEN SAMPLE AREAS

Urban Areas	1959			1960		
	Males	Females	Total	Males	Females	Total
London Administrative Area (3,194,480) ..	263	92	355	463	78	541
Merseyside (Liverpool, Bootle, Birkenhead, and Wallasey) (1,084,980)	50	8	58	74	1	75
Manchester and Salford (826,760)	10	3	13	12	6	18
Tyneside (Newcastle, South Shields, and Tynemouth (447,580)	6	7	13	10	3	13
Hull (302,400)	5	2	7	7	3	10
Southampton (201,790)	9	1	10	11	0	11
Bristol (433,750) ..	22	5	27	26	7	33
Birmingham (1,093,160)	7	4	11	15	6	21
Leeds and Bradford (804,620)	1	2	3	3	3	6
Sheffield, (499,610) ..	3	1	4	4	1	5

Note.—The figures in brackets are the estimated populations at June 30, 1960.

Cases in the London area show an appreciable increase in respect of males, thus continuing the trend of recent years; those in females show a moderate decrease. On Merseyside, where the number decreased in 1959, there was an increase in 1960. The fact that only one female with infectious syphilis was diagnosed and treated in this area is probably related to the fact that most of the infected men were seamen who had contracted infection abroad. Most other centres show slight increases, but the numbers are small and the figures suggest that London is the main focus of this type of infection.

The further decline in the numbers of new patients with late syphilis presumably reflects the low prevalence of infectious syphilis in the population for

* Part II of the Report of the Ministry of Health for the year ended December 31, 1960. Cmnd. 1550, p. 56. Appendix C, p. 225.

some years past, although the fact that more late cases may now be treated elsewhere than at the venereal diseases clinics has perhaps contributed to this fall. Some details are shown in the Table which follows. From this it may be seen that there is some reduction in the numbers of cases of neurosyphilis and of all other late and latent infections with the exception of cases of cardiovascular syphilis.

LATE SYPHILIS, 1959 AND 1960

Late Syphilis	Year	Males	Females	Total
Cardiovascular Syphilis ..	1959	193	85	278
	1960	204	79	283
Neurosyphilis	1959	307	151	458
	1960	252	139	391
All Other Late or Latent Stages	1959	1,075	971	2,046
	1960	1,011	878	1,889
Total Late or Latent Syphilis	1959	1,575	1,207	2,782
	1960	1,467	1,096	2,563

As in recent years, the cases reported as latent syphilis probably include some old-standing latent yaws contracted in childhood by immigrants from the West Indies and other places where yaws is or has been endemic. If a patient gives the history of yaws or has characteristic scars on the legs with positive serological tests, the diagnosis of yaws is usually made. If there is no information other than the positive tests, the case is likely to be entered as one of latent syphilis. In 1960 yaws was diagnosed in 405 cases as compared with 301 in 1959.

The Registrar General's figures for 1960 show a further small decline in deaths from general paralysis of the insane and from tabes dorsalis. This is satisfactory but does not necessarily indicate a decline in incidence; with modern methods of treatment death from these causes is less likely. It is interesting to note that two recent reports from physicians in charge of observation wards have described increases in numbers of cases of general paralysis under their care. Deaths from syphilitic aortic aneurysm show an increase in males and a small reduction in females, but the numbers are not large (Appendix, Table E).

The number of new cases of congenital syphilis in infants of less than one year was eighteen, as compared with twenty in 1959. The death rate of infants under one year certified in returns to the Registrar General as dying from congenital syphilis was nil compared with the rate of 0·003 per 1,000 live births in 1959. Satisfactory as these figures are, it cannot be stated too often that constant vigilance is necessary to maintain this excellent record, more especially in view of the increase of infectious syphilis in adults. The most effective methods of preventing congenital syphilis are the detection and treatment of cases of infectious syphilis and the performance of routine serological tests for syphilis on all pregnant women. Whether patients attend hospitals, Local Authority clinics, or their own doctors for antenatal care, serological tests should be done. The number of cases of late congenital syphilis reported from the clinics (Appendix, Table C) was 371 in 1960, a slight increase on the figure for 1959 which was 352.

Testing for Syphilis in Pregnancy.—Results of serological tests for syphilis on pregnant women are shown in the following Table. They were received from six regional blood transfusion centres where these routine tests are performed for the regions concerned.

A summary of results of tests on sera of primiparae and multiparae at these centres for the past 7 years, given below, shows that the percentage incidence of positive tests is very small and continues to decline. Nevertheless it is still sufficient to justify routine testing of all expectant mothers, because of

CASES OF ANTENATAL SYPHILIS, 1960, AT SIX REGIONAL CENTRES

Regional Blood Transfusion Centre	No. of Ante-natal Patients Tested			Positive Syphilis Tests				
	Primiparae	Multiparae	Parity not known	Primiparae		Multiparae		Parity not known
				No.	Per cent.	No.	Per cent.	No.
Cambridge	8,810	3,926	944	7	0·08	11	0·28	—
Leeds	9,726	8,682	3,350	13	0·13	16	0·18	5
Liverpool	22,330	21,250	—	5	0·02	10	0·05	—
Oxford	2,342	2,712	363	—	—	2	0·07	—
Plymouth	2,284	1,705	—	9	0·39	15	0·88	—
Sheffield	16,114	8,074	—	16	0·09	11	0·14	—

In addition 48 doubtful results were recorded in primiparae and 41 in multiparae.

the substantial benefit of treatment in the antenatal period.

Year	Primiparae		Multiparae	
	No.	Percentage Positive	No.	Percentage Positive
1953 ..	28,263	0·21	27,573	0·43
1954 ..	39,181	0·23	47,941	0·32
1955 ..	41,392	0·21	40,712	0·43
1956 ..	48,420	0·28	40,295	0·35
1957 ..	49,914	0·14	43,730	0·29
1958 ..	49,315	0·13	40,765	0·23
1959 ..	56,962	0·14	46,531	0·16
1960 ..	61,606	0·08	46,349	0·14

Gonorrhoea.—The number of new cases of gonorrhoea diagnosed at the clinics again rose, from 31,344 in 1959, when the number was the highest since 1947, to 33,770 in 1960. The increase in 1960 over 1959 was 8 per cent. as compared with an increase of 12 per cent. in 1959 over 1958. There is not much satisfaction to be gained from these figures, but it does seem that the rate of increase may be slowing. As in other years, the numbers are swollen by the fact that some patients contracted this disease on more than one occasion in the course of the year and each attack is recorded as one case. The Table below indicates the manner in which multiple infections affected the figures for cases of gonorrhoea at seven large clinics—four in London and three in the provinces—during 1959.

CASES OF GONORRHOEA, 1959, IN SEVEN LARGE CLINICS

Clinic	New Infections		Patients	
	Males	Females	Males	Females
The London Hospital.. ..	1,608	446	1,248	391
St. Mary's Hospital, London..	2,815	668	2,532	450
SS. Peter's and Paul's Hospital London	1,169	160	921	132
St. Thomas's Hospital, London	971	216	824	176
General Hospital, Birmingham	1,145	244	940	229
St. Luke's Clinic, Manchester	1,239	325	1,014	300
General Hospital, Newcastle-on Tyne	279	103	248	92

Some of the reasons for the increase in gonorrhoea were discussed in this report for 1959. The Working Party of the Medical Research Council, which has been investigating the problem of gonococci partially resistant to penicillin, has confirmed the existence of some relatively insensitive strains in various parts of the country. The number of such strains and the degree of their resistance to penicillin vary greatly from place to place and, in some areas from time to time. As yet there is no evidence that totally resistant strains are likely to emerge, nor that partially resistant strains are likely to predominate and render accepted methods of treatment inadequate. On the other hand, there is considerable danger from the fact that, in cases of patients harbouring partially resistant strains, the effect of treatment may be to suppress the symptoms of infection without achieving cure. If these patients assume that cure has occurred and consequently discontinue attendance, as they are very apt to do, there is likelihood of spread of this infection among promiscuous people.

Evidence from the clinics indicates that prostitutes and other promiscuous women continue to provide the important reservoir of infection. At H.M. Prison, Holloway, the consultant venereologist again reported a high incidence of infection among prostitutes. The number of known prostitutes admitted during 1960 was 528 of whom 476 submitted to examination and tests for venereal disease. Of these, one per cent. were found to be suffering from syphilis and 36 per cent. from gonorrhoea. Of the total number of prostitutes, 166 (31 per cent.) were between the ages of 15 and 20 years and of the 152 of these young women who submitted to examination, seventy (46 per cent.) were found to be suffering from gonorrhoea. As in previous years, many of the women in whose cases the diagnosis of venereal disease was not established had symptoms and signs suggestive of disease but were not under observation sufficiently long to exclude communicable infection.

The Adviser in Venereology to the Manchester Regional Hospital Board described a progressive rise in the incidence of gonorrhoea in the Manchester area from the latter part of 1956 until September, 1959, and it was known that 30 per cent. of males with gonorrhoea in this area admitted exposure with prostitutes. In the twelve months ending September, 1960, there was a fall in the incidence of gonorrhoea in all parts of Manchester. The only local change which was evident was a great reduction in street prostitution following the implementation of the Street Offences Act in August, 1959. There was no reduction in the numbers of cases of diseases other than gonorrhoea and there was, in fact, an increase in non-gonococcal urethritis. During the past 6 months gonorrhoea in Manchester has again increased, coincident with an increase in activity of prostitutes frequenting public houses and, to a lesser extent, dance halls, but the incidence appears still to be less than it was in the 3 months before August, 1959.

Immigrants, many of whom admit association with prostitutes and other promiscuous women, continue to contribute considerably to the total of gonococcal infections, and there is still much anxiety

about the increase in promiscuity, and therefore of venereal disease, among people under the age of 20.

A report from the Adviser in Venereology to the Liverpool Regional Hospital Board stated that, during 1960, 471 young men and boys between the ages of 14 and 19 attended the clinics of Liverpool, a total of 8·6 per cent. of all the males who attended. There were also 388 girls and women between the ages of 11 and 19, amounting to 37·4 per cent. of all the females who attended.

Other Venereal Diseases.—New cases of chancroid decreased to 231 in 1960, as compared with 267 in 1959. This disease has never been common in this country but the present figures are the lowest on record. There were 102 cases of lymphogranuloma venereum, as compared with eighty in 1959 and fourteen cases of granuloma inguinale as compared with twelve in 1959. Non-gonococcal urethritis in the male again increased from 20,227 cases in 1959 to 22,004 cases in 1960 (Appendix, Table A). The cause of this condition is unknown and it may, in fact, comprise a group of diseases. Some cases are relatively intractable to treatment and many are prone to relapse. In a small number complications are serious and may produce permanent disability. At the present time it is the most difficult problem encountered at the clinics and offers perhaps the major hazard to the promiscuous individual. In the female it cannot be clearly distinguished as a clinical entity and contacts of men with non-gonococcal urethritis are included under the heading "other conditions requiring treatment". The number of cases of women in this category again increased from 12,752 in 1959 to 15,199 in 1960.

Other Conditions treated at the Clinics.—The clinics are required to deal with many patients who are not suffering from venereal diseases and this is a most important part of their work. Advice is sought by those who have taken risks and are anxious, by those who have non-venereal conditions of the genitalia which have to be distinguished from infectious disease, and by those who require reassurance because of the abnormal fears which these diseases sometimes induce. In Table A of the Appendix it may be seen that, during 1960, there were 32,592 cases of other diseases which nevertheless required treatment and 36,963 cases in which treatment, other than advice and reassurance, was not required. These figures compare with 27,993 and 32,704 for the equivalent groups in 1959, and give further evidence of the regard in which the clinics are held by both the patients and the doctors who refer them.

The Present Position.—These figures for venereal infections in 1960 in a prosperous and stable society at peace are matters for considerable concern. Syphilis is still numerically a small problem, but the rise in the number of infectious cases demands increasing awareness from public health authorities and from the medical profession in general. The major problems of gonorrhoea and non-gonococcal urethritis continue to cause serious anxiety, although it is some slight consolation that the rate of increase appears to be slackening. The factors which contribute to the increase show no sign of change at the present time. Movements of population with consequent disruption of family life are always prone to cause spread of venereal disease and while immigration continues at the present rate this is a hazard which must be expected. At the other end of the scale many immigrants have established themselves in stable circumstances and are no longer subject to the stresses and strains which lead to promiscuity and infection. The contribution which organized and unorganized prostitution make to this problem is considerable and this is not a matter which can be solved only by medical means. Confirmed prostitutes are often unco-operative and unlikely to respond to educational measures. Those who insist on leading this kind of life may, at any rate, be encouraged to use the facilities of the clinics in their own interest. It seems most likely that the pattern for habitual promiscuity is determined by faulty upbringing in early life, by bad example, and by bad companionship. There is no simple or obvious remedy for these unfortunate people and it is a tragedy that many must bequeath the same pattern to their children. As part of long-term procedure by which it may be hoped to improve the sexual habits of society, it is essential to obtain detailed and accurate information. The investigation into the causes of sexual attitudes and activities among young people, sponsored by the Central Council of Health Education with the aid of funds from the Nuffield Foundation, is now taking shape. The British Medical Association also has set up a committee embracing representatives of religious bodies, education, and social services to look into the wider aspects of these problems, including practical measures for (1) combating venereal disease; (2) promoting co-operation between religious bodies, the medical profession, and social services; (3) influencing public opinion; and (4) co-ordinating the activity of the various bodies already at work in this field.

In the meantime there is something to be gained by providing accurate information about the

venereal diseases through the various media which inform the public. Recently informative articles in newspapers and journals have increased in number and have been helpful. There is a good case for repeating or improving upon two television programmes which reached large audiences in November, 1959, and March, 1960. The co-operation of youth clubs and similar organizations in the dissemination of information might well give good results. The ultimate responsibility, however, rests with parents, whose duty it is to train the minds and develop the characters of their children.

APPENDIX

TABLE A

NUMBER OF CASES (IN ALL STAGES) DEALT WITH FOR THE FIRST TIME AT ANY CENTRE, 1950–60*

Sex	Year	Syphilis	Soft Chancre	Gonorrhoea	Non-Gonococcal Urethritis (Males only)	Other Conditions†		Total Sum of Columns 2–6
						Requiring Treatment	*Not Requiring Treatment*	
	1950	5,979	433	17,007	—	55,058		78,487
	1951	4,506	437	14,975	10,794	11,607	26,956	69,275
	1952	3,760	389	15,510	11,552	12,578	25,928	69,717
	1953	3,272	347	15,242	13,157	13,566	25,619	71,203
Male	1954	2,929	301	13,962	13,279	13,071	24,651	68,193
	1955	2,711	285	14,079	14,269	13,613	24,436	69,393
	1956	2,778	307	16,377	14,825	14,254	23,514	72,055
	1957	2,747	254	19,620	16,066	14,332	23,032	76,051
	1958	2,497	247	22,398	17,606	14,562	21,711	79,021
	1959	2,252	265	24,964	20,227	15,241	23,160	86,109
	1960	2,401	226	26,618	22,004	17,393	26,087	94,729
	1950	4,988	17	3,497	—	23,840		32,342
	1951	3,926	16	3,089	—	8,517	12,408	27,056
	1952	3,362	14	3,585	—	8,916	11,560	27,437
	1953	2,914	9	4,021	—	9,834	10,612	27,390
Female	1954	2,352	8	3,574	—	10,117	9,503	25,554
	1955	2,272	10	3,766	—	10,182	9,075	25,305
	1956	2,363	9	4,011	—	10,939	8,835	26,157
	1957	2,230	6	4,761	—	11,317	9,098	27,412
	1958	1,829	12	5,489	—	12,149	9,001	28,480
	1959	1,675	2	6,380	—	12,752	9,544	30,353
	1960	1,545	5	7,152	—	15,199	10,876	34,777

* Excludes cases transferred from centre to centre.

† Including non-gonococcal urethritis up to 1950.

TABLE B

CASES OF ACQUIRED SYPHILIS IN TABLE A, WITH INFECTIONS OF LESS THAN ONE YEAR, 1950–60

Year	Number of Cases		Per cent. of Table A Cases	
	Male	Female	Male	Female
1950	2,678	1,465	44·8	29·4
1951	1,498	774	33·2	19·7
1952	891	462	23·7	13·7
1953	755	319	23·0	10·9
1954	600	208	20·5	8·9
1955	609	228	22·5	10·0
1956	587	257	21·1	10·8
1957	555	192	20·2	8·6
1958	522	182	20·9	9·9
1959	564	209	25·0	12·5
1960	819	175	34·1	11·3

TABLE C

CASES OF CONGENITAL SYPHILIS DEALT WITH FOR THE FIRST TIME AT THE TREATMENT CENTRES, 1950–60

Year	Under 1 year	1 and under 5 years	5 and under 15 years	15 years and over	Totals
1950	227	141	203	652	1,223
1951	156	89	198	684	1,127
1952	110	101	191	547	949
1953	95	77	152	520	844
1954	48	41	119	478	686
1955	41	30	114	459	644
1956	36	31	82	441	590
1957	27	26	77	427	557
1958	17	15	65	340	437
1959	20	19	29	304	372
1960	18	10	38	323	389

TABLE D

DEATH RATES PER 1,000 LIVE BIRTHS, OF INFANTS UNDER 1 YEAR CERTIFIED AS DUE TO CONGENITAL SYPHILIS, 1912–60

Year	Rate	Year	Rate	Year	Rate	Year	Rate
1912	1·34	1924	0·91	1936	0·24	1948	0·09
1913	1·46	1925	0·82	1937	0·19	1949	0·08
1914	1·55	1926	0·84	1938	0·18	1950*	0·04
1915	1·44	1927	0·77	1939	0·17	1951*	0·03
1916	1·57	1928	0·71	1940	0·16	1952*	0·03
1917	2·03	1929	0·64	1941	0·21	1953*	0·01
1918	1·90	1930	0·55	1942	0·19	1954*	0·003
1919	1·76	1931	0·45	1943	0·23	1955*	—
1920	1·51	1932	0·42	1944	0·16	1956*	—
1921	1·43	1933	0·35	1945	0·15	1957*	—
1922	1·12	1934	0·30	1946	0·15	1958*	0·004
1923	1·05	1935	0·26	1947	0·09	1959*	0·003
						1960*	—

Rates for years 1931–49 are according to the 1940 classification (5th Revision). For 1912–30 the rates need to be multiplied by the conversion ratio 0·857 for approximate comparability.

* For 1950–60 No. 020.2 in International List (7th Revision).

TABLE E

DEATHS FROM GENERAL PARALYSIS OF THE INSANE, TABES DORSALIS, AND ANEURYSM OF THE AORTA, 1911–60

Year	General Paralysis of the Insane		Tabes Dorsalis		Aneurysm of Aorta*	
	Males	Females	Males	Females	Males	Females
1911–20	1,697	383	592	106	838	208
1921–30	1,204	277	631	127	860	249
1931–35	819	240	566	125	969	393
1936–39	625	227	471	106	1,017	531
1940–44	482	167	270	71	367	124
1945–49	258	101	157	41	381	130
1950–54	98	42	93	27	336	166
1955	84	36	53	24	332	173
1956	56	28	66	15	329	171
1957	48	20	53	22	358	183
1958	57	28	41	16	307	219
1959	62	27	50	22	295	190
1960	56	22	44	17	312	186

The averages for the years 1911 to 1939 are based on the 4th Revision of the International List. Figures for the years 1940 to 1960 are according to the 7th Revision.

Non-civilian deaths are excluded from September 3, 1939, for males, and from June 1, 1941, for females, to December 31, 1949.

* For years 1911–1939:
"Aneurysm" (code 96) of the 4th Revision List, based on arbitrary rules of assignment.
For years 1940 and after:
"Aneurysm of Aorta" (code 022) of the 7th Revision List, based on assignment by the certifying medical practitioner.

BOOK REVIEW

Advances in the Biology of the Skin. Vol. 2, Blood Vessels and Circulation. Edited by W. Montagna and R. A. Ellis, 1961. Pp. 156, 117 figs. Pergamon Press, Oxford. (63*s*.).

Very few research workers in any field escape the problem presented by the need for more information on the normal state. This volume is for investigators who have a special interest in vascular physiology. Methods of studying the skin circulation are explained, and extensive studies of the normal state are presented. The photographs are quite magnificent, and the difficult subject of capillary microscopy is well portrayed. The fairly extensive bibliography is modern and practical.

This book should be in the hands of all those interested in the behaviour of blood vessels, and not confined to "investigative dermatologists".

M.G.